

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:

County Frederick
 City or town Thurmont
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Thurmont
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. East Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Nora Elizabeth Ambrose.

3. (b) Social Security Number

none.

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age.....years

7. Birth date of

deceased (mo., day, yr.)

October 23, 1880

8. AGE:

Years

Months

Days

If less than one day

64420

hrs.

min.

9. Birthplace

Keymar, Frederick Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

Frank Zent.

13. Birthplace

Carroll County, Md.

MOTHER

14. Maiden name

Margaret Needy

15. Birthplace

Smithsburg, Wash. Co., Md.

16. Informant

Charles R. Ambrose

Address

Thurmont, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

March 13, 1945

Cemetery or crematory

Blue Ridge

Location

Thurmont, Md.

18. Funeral director

M. L. Creager & Son

Address

Thurmont, Md.

19. Mar. 13

(Date rec'd by registrar)

19 45Anna M. Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15, 1944 to March 10, 1945
 and that I last saw her alive on March 10, 1945

Immediate cause of death

DURATION

Heart disease Organic
chronic myocarditis

3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James H. Gray
Thurmont, Md.
 Address..... Date signed 3/12/45

NEW YORK STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 4 1945

BUREAU V.S.

RECEIVED NEW YORK STATE DEPARTMENT OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore ^{93d}

CERTIFICATE OF DEATH

02875

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
Frederick-R. F. D. #5 (Braddock)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Braddock

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City Frederick-R. F. D. #5
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Braddock

(If rural, give LOCATION)

2(a) If veteran, name war None

3. (a) FULL NAME

DAISY SUSANNAH REBECCA BAST

3. (b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, divorced <u>S</u>
--------------------	------------------------------	---

6. (b) Name of husband or wife

B. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) September 8, 1874

8. AGE: Years <u>70</u>	Months <u>6</u>	Days <u>7</u>	If less than one day _____ hrs. _____ min.
----------------------------	--------------------	------------------	---

9. Birthplace Braddock-Frederick-Maryland
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Simeon L. Bast
 13. Birthplace Frederick County Maryland

MOTHER 14. Maiden name Ann J. Cutsail
 15. Birthplace Frederick County Maryland

16. Informant Mrs. Elmegia B. KrantzAddress E. 2nd St., Frederick, Maryland

17. Burial Date thereof 3/17/45
 (Burial, cremation or removal) (month) (day) (year)

Cemetery or Mount Olivet CemeteryLocation Frederick, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland

19. 16 March 1945 Elizabeth G. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th, 1945 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1944 to March 15, 1945
 and that I last saw him alive on March 14, 1945

Immediate cause of death Coronary artery

chronic myocarditis, duration 5 years
 Due to 5 years

Due to

Benign Prostatic Gland
 Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE Frank H. Hecker M. D.

M. D. or other

Address Frederick, Maryland Date signed 3-16-45

RECEIVED

MAR 20 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16457

CERTIFICATE OF DEATH

02876
Reg. Dist. No. 140

1. PLACE OF DEATH:

County FrederickCity or town Woodlboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Woodlboro
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Ross Melancthon Boller

3. (b) Social Security Number

214-10-27764. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Margaret S. Heddle7. Birth date of deceased (mo., day, yr.) Aug. 3, 1875 6. (c) If alive, give age 50 years8. AGE: Years 69 Months 7 Days 15 If less than one day _____ hrs. _____ min.9. Birthplace Frederick Co. Md.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Brush Factory12. Name Isaiah Boller13. Birthplace Md.14. Maiden name Susan Smith15. Birthplace Md.16. Informant Mrs. Ross M. BollerAddress Woodlboro, Md.17. Burial Date thereof Mar 21, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. HopeLocation Woodlboro, Md.18. Funeral director Buell & HartzlerAddress Woodlboro, Md.19. Mar 19, 1945 L. B. Powell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____

and that I last saw him dead March 18, 1945Immediate cause of death Strangulation

DURATION

5 minDue to Strangulation

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 3.18.45Where did injury occur? Woodlboro, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Room of homeMeans of injury Strangulation Injured at work? no23. SIGNATURE R. W. 13m Deputy Med
M. D. or other ExpAddress Woodlboro, Md. Date signed 3.18.45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DATE OF DEATH

REC'D

APR 4 1945

BUREAU V.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02877

1. PLACE OF DEATH

County Frederick Registration Dist. No. 138
 Village or City Sparksville No. Riggs Cottage Sanitarium Ward
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred 5 yrs. 8 mos. — ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME

Bettie S. Burns
 (a) Residence: No. Charleston, W. Va. Ward. Charles Town, W. Va.
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5a. If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of J. E. Burns

6. DATE OF BIRTH (month, day, and year) Jan 28, 1856

7. AGE Years 89 Months — Days — If LESS than 1 day, — hrs. or — min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife
 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —
 10. Date deceased last worked at this occupation (month and year) 1936 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Shepherdstown
 (State or country) West Va.

FATHER 13. NAME E. Pearson Shugart

14. BIRTHPLACE (city or town) Penn.
 (State or country)

MOTHER 15. MAIDEN NAME Elizabeth Miller

16. BIRTHPLACE (city or town) W. Va.
 (State or country)

17. INFORMANT Dr. J. E. Burns
 (Address) Charleston, W. Va.

18. BURIAL, CREMATION, OR REMOVAL
 Place Charleston Date Mar. 30, 1945

19. UNDERTAKER Melvin T. Slider
 (Address) Charles Town, W. Va.

20. FILED 28 March, 1945 Lucian K. Takam
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Mar 28 1945
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Aug 24 1939, to Mar 28 1945

I last saw him alive on Mar 28 1945; death is said to have occurred on the date stated above, at 1:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Chronic Myocarditis
Coronary Arteriosclerosis 1936?
 Date of onset —

Other Contributory Causes of Importance:

General Arteriosclerosis
Sclerosis

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury —, 19—

Where did injury occur? — (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) George W. Miller M. D.

(Address) Sparksville, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

02878

131

Reg. Dist. No.

1. PLACE OF DEATH:
County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
Frederick City Hospital
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 423 North Bentz Street
(If rural, give LOCATION)
None
2.(a) If veteran, name war.....

3. (a) FULL NAME
HETTIE ANN CARMACK

3. (b) Social Security Number
None

4. Sex F 5. Color or race W 6. (a) Single married, widowed, or divorced W

6. (b) Name of husband or Calvin P. Carmack

7. Birth date of deceased (mo., day, yr.) September 9, 1874 8. (c) If alive, give age..... years

8. AGE: Years 70 Months 5 Days 28 If less than one day..... hrs. min.

9. Birthplace Mercersburg, Penna.
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name James Briggs

13. Birthplace Mercersburg, Penna.

14. Maiden name Sarah

15. Birthplace Mercersburg, Penna.

16. Informant Mrs. Paul E. Himes

Address 423 N. Bentz St., Frederick, Md.

17. Burial Date thereof 3/10/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Frederick Memorial Park

Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 8 March 1945 Elizabeth H. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7th, 1945 at 4:25 P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 15, 1945 to March 7, 1945

and that I last saw him alive on March 7, 1945

Immediate cause of death..... DURATION.....

Due to carcinoma of liver

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations carcinoma of liver

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury fall Injured at work?

23. SIGNATURE M. D.

Frederick, Maryland Date signed 3-8-45

RECEIVED

RECEIVED

RECEIVED

MAR 12 1945

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

02879

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
Jefferson-Rural R. F. D. #1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or address where death occurred:
Near Jefferson
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
Jefferson-Rural R. F. D. #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Jefferson
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... None

3. (a) FULL NAME

DOROTHY MILLER CARRICK

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) ~~Single~~ married, widowed, or divorced M

6.(b) Name of husband or Edwin W. Carrick

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) July 18, 1916

8. AGE: Years 28 Months 5 Days 16 It less than one day
hrs.min.

9. Birthplace West Virginia
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Victoria Miller

15. Birthplace West Virginia

16. Informant Mrs. Lory See

Address Jefferson, Md. R. F. D. #1

17. Burial Date thereof 3/6/45
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory New Dale Cemetery

Location New Dale, West Virginia

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 5 March 1945 Elizabeth G. Hicks
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4 19 45 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 44 to Mar 4 19 45

and that I last saw him alive on Feb 26 19 45

Immediate cause of death.....

Tuberculous enteritis

Tuberculosis with Cantation

Due to Life infection

Due to.....

Other conditions Tuberculous enteritis

not this infection

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Lachet Lucie M. D.

M. D. or other

Address Jefferson Md Date signed 3/4/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

NOTICE TO THE PUBLIC

RECEIVED
MAR 8 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

02880

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, institution, or street address where death occurred:
Frederick City Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Adamstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
none
2.(a) If veteran, name war _____

3. (a) FULL NAME

GRACE ELIZABETH COMPHER

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife C. Elmer Compher

7. Birth date of deceased (mo., day, yr.) July 11, 1877 8. (c) If alive, give age 68 years

8. AGE: Years 67 Months 8 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Adamstown, Frederick Co., Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

FATHER 12. Name Marion S. Michael

13. Birthplace Frederick County, Maryland

MOTHER 14. Maiden name Alice Copeland

15. Birthplace Frederick County, Maryland

16. Informant C. Elmer Compher

Address Adamstown, Maryland

17. Burial Date thereof March 25, 1945
(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Frederick, Maryland

18. Funeral director C. E. Cline & Son

Address Frederick, Maryland

19. 23 March 1945 (Date rec'd by registrar)

Elizabeth G. Hark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 45 at 10:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 19 45 to March 22 19 45 and that I last saw him alive on March 22 19 45

Immediate cause of death Cerebral thrombosis DURATION 3 weeks

Due to Hypertension arteriosclerosis 10 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other

Address [Signature] Date signed 23.3.45

CERTIFICATE OF DEATH

RECEIVED

MAR 28 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137

CERTIFICATE OF DEATH

02881

Reg. Dist. No. 139

1. PLACE OF DEATH:
County Frederick
City or town State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 1/10/41
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Since 1/10/41

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3403 - 35th St.
(If rural, give LOCATION)
2.(a) If refered, name war

3. (a) FULL NAME
John Connolly

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 23, 1887 6. (c) If alive, give age years

8. AGE: Years 57 Months 5 Days 8 If less than one day hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

FATHER 12. Name James Connolly
13. Birthplace Washington, D.C.

MOTHER 14. Maiden name Margaret Burke
15. Birthplace Ireland

16. Informant Deceased
Address

17. Burial Date thereof unknown
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Oliver Cemetery
Location Washington D.C.

16. Funeral director D.R. Valley
Address Mt. Rainier Md.
3/31/45

19. (Date rec'd by registrar) 19 3/31/45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 45, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 19 41, to March 31 19 45, and that I last saw him alive on March 31 19 45.

Immediate cause of death Pulmonary Tuberculosis DURATION 5 Yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Lynn M. D. JOHN

Address State Sanatorium, Md. Date signed 3/31/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Frederick

RECEIVED

APR 6 1945

APR 17 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02882

131

Reg. Dist. No.

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

31 East Fourth Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 31 East Fourth Street

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3. (a) FULL NAME

ALBERT FILMORE COOK

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M6. (b) Name of ~~husband~~ or wife Maggie Burdette6. (c) If alive, give age 69 years7. Birth date of deceased (mo., day, yr.) October 19, 1870

8. AGE:

Years

Months

Days

If less than one day

74427

hrs.

min.

9. Birthplace Nr. Jefferson-Frederick-Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business

FATHER
MOTHER12. Name Benjamin Cook13. Birthplace Frederick County Maryland14. Maiden name Elizabeth Stockman15. Birthplace Frederick County Maryland16. Informant Mrs. Maggie B. CookAddress 31 E. 4th St., Frederick, Md.17. Burial Date thereof 3/18/45

(Burial, cremation, or removal-Which)

(month) (day) (year)

Cemetery or crematory Mount Olivet CemeteryLocation Frederick, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 16 March 1945 Elizabeth G Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16th, 1945 at 4:15A M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 8, 1945 to March 16, 1945 and that I last saw him alive on March 13, 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 daysDue to Hypertensive Cardia
Vascular Disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Howard W. Cook M.D.
M. D. or otherAddress Frederick Md Date signed 3/16/45

CERTIFICATE OF DEATH

RECEIVED

MAR 20 1945

BUREAU

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

02883

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, institution, or street address where death occurred:
7 East Third Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 East Third Street
(If rural, give LOCATION)
None
2.(a) if veteran, name war

3. (a) FULL NAME

FLORENCE MAY COOK

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W

6. (b) Name of husband or wife George L. Cook

7. Birth date of deceased (mo., day, yr.) January 15, 1873 8. (c) If alive, give age years

8. AGE: Years 72 Months 2 Days 8 If less than one day
..... hrs. min.

9. Birthplace Nr. Jefferson-Frederick-Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name George S. Stockman

13. Birthplace Frederick County Maryland

MOTHER 14. Maiden name Alice F. Hargett

15. Birthplace Frederick County Maryland

16. Informant Miss Myrtle M. Cook

Address 7 E. 3rd St., Frederick, Md.

17. Burial Date thereof 3/26/45

(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Lutheran Cemetery

Location Jefferson, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 26 March 1945 Elizabeth G. Heck

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd, 1945 10:45P.

21. CERTIFY that death occurred on the date above stated; that attendant deceased from 1 day 28 to 1st March 1945

and that I last saw him alive on March 23 1945

Immediate cause of death

Cerebral thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. R. Etchison M. D.

Address Frederick, Maryland Date signed 3-26-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
MAR 28 1966
BUREAU OF VITALS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

Reg. Dist. No. 02884/41

1. PLACE OF DEATH:

County..... Frederick
 City or town..... Brunswick, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 9 days
 Hospital, institution, or street address where death occurred:
Schnauffers Hospital
 How long in hospital or institution?..... 9 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... W. Va. County..... Jefferson
 City or town..... Bolivar, W. Va.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

Nettie Gertrude Crawford

3. (b) Social Security Number

No

4. Sex..... Female
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Divorced

6. (b) Name of husband or wife..... William Crawford

7. Birth date of deceased (mo., day, yr.)..... November 17 1873
 6. (c) If alive, give age..... 66 years

8. AGE: Years..... 71 Months..... 3 Days..... 18
 If less than one day..... hrs. min.

9. Birthplace..... Martinsburg, W. Va.
(Town, county, and state)10. Usual occupation..... House Keeping11. Industry or business..... Home

FATHER 12. Name..... Edward Thomas Kirby
 13. Birthplace..... England

MOTHER 14. Maiden name..... Mary Elizabeth Wilson
 15. Birthplace..... Bolivar, W. Va.

16. Informant..... Mrs Arys Green
 Address..... Bolivar, W. Va.

17. Burial..... Mar 10 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Harper Cemetery
 Location..... Harpers Ferry, W. Va.

18. Funeral director..... J. H. Beachler
 Address..... Bolivar, W. Va.

19. March 7 1945..... Emma Martin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 6 1945 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1945 to March 6 1945
 and that I last saw him alive on March 6 1945

Immediate cause of death..... Cerebral Hemorrhage
 DURATION..... 10 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... William Beachler M. D. or otherAddress..... Brunswick Date signed..... March 6

RECEIVED

CERTIFICATE OF DEATH

RECEIVED
APR 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48a K

CERTIFICATE OF DEATH

02885

Reg. Dist. No. 140

1. PLACE OF DEATH

County FrederickCity or town 2 Woodsboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County FrederickCity or town 2 Woodsboro
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Pansy Irene Grum

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Frank J. Grum7. Birth date of deceased (mo., day, yr.) July 29, 18808. AGE: Years 64 Months 7 Days 20 If less than one day _____ hrs. _____ min.9. Birthplace Frederick Co. Md.
(Town, county, and state)10. Usual occupation House wife11. Industry or business Own home12. Name John W. Fox13. Birthplace Frederick Co. Md.14. Maiden name Sarah S. Fox15. Birthplace Frederick Co. Md.16. Informant Henry P. GrumAddress 2 Woodsboro Md.17. Burial Date thereof Mar. 21, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory N.Y. HopeLocation 2 Woodsboro, Md.18. Funeral director Burke & HartylerAddress 2 Woodsboro Md.19. Mar. 21, 1945 L. B. Powell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19, 1945 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 12, 1945 to March 19, 1945and that I last saw her alive on March 18, 1945

Immediate cause of death _____

Carcinoma Cervix
with Metastasis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____. Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Samuel F. Fosterday
M. D. or other _____Address Walkersville, Md. Date signed 3/20/45

CERTIFICATE OF DEATH

1.

APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age & birth date of deceased is
shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

CERTIFICATE OF DEATH

Reg. Dist. No. 131

FILM No. G 94 MAY 11 1945

1. PLACE OF DEATH:

County..... Frederick
City or town..... Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 10 years
Hospital, institution, or street address where death occurred:
..... 40 East Seventh Street
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Frederick
City or town..... Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 40 East Seventh Street
(If rural, give LOCATION)
2.(a) If veteran, name war..... None

3. (a) FULL NAME

CORA VICTORIA DANNER

3. (b) Social Security Number
None

4. Sex..... Female
5. Color or race..... White
6. (a) Single, married, widowed, or divorced..... Widowed

6. (b) Name of husband or wife..... Harry S. Danner

7. Birth date of deceased (mo., day, yr.)..... July 19, 1871 1870

8. AGE: Years..... 74 Months..... 8 Days..... 7 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... None

12. Name..... James M. Mull

13. Birthplace..... Loudon County, Virginia

14. Maiden name..... Cornelia Catherine Whipp

15. Birthplace..... Frederick County, Maryland

16. Informant..... Harry F. Danner

Address..... Frederick, Maryland

17. Burial..... Date thereof..... March 22, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Olivet Cemetery

Location..... Frederick, Maryland

18. Funeral director..... C. E. Shline & Son

Address..... The Denicks - Maryland

19. 27 March 1945 Elizabeth G. Hach. Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 26 1945 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1944 to March 26 1945 and that I last saw her alive on March 26 1945

Immediate cause of death..... Cerebral Hemorrhage

Due to..... Supertension Arterio - Vascular Disease

Due to.....

Other conditions..... Diabetic Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Howard W. Ash M.D.

Address..... Frederick Md Date signed 3/31/45

RECEIVED
MAR 29 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

CERTIFICATE OF DEATH

Reg. Dist. No. 139

02887
139

1. PLACE OF DEATH:
County... Frederick
City or town... Sabillasville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland. County... Frederick
City or town... Foxville- rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
no
2. (a) If veteran, name war

3. (a) FULL NAME
William Luther Delawter

3. (b) Social Security Number
none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Addie Belle Lantz

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 5, 1858

8. AGE: Years 87 Months 0 Days 15 If less than one day
..... hrs. min.

9. Birthplace Foxville, Frederick Co., Md
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Farming

12. Name George W. Delawter

13. Birthplace Foxville, Md.

14. Maiden name Isabelle Brown.

15. Birthplace Foxville, Md.

16. Informant John Delawter

Address Sabillasville, Md.

17. Burial Date thereof March 23, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory United Brethern

Location Thurmont, Md.

18. Funeral director M. L. Creager & Son.

Address Thurmont, Md.

19. Mich 22 1945 B.E. Shields
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1945 10:15 P: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1942, to Mar. 20 1945
and that I last saw him alive on Mar. 20 1945

Immediate cause of death.....

Heart disease - organic
Chronic Myocarditis

Due to.....

Due to.....

Other conditions Old age debility

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, term, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. Gray MB
M. D. or other

Address Thurmont Md. Date signed 3/22/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

02888

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick Co., Md.City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick - Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Mt. Airy R.D.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES BOYD DIVERS

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 20, 1920

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

24

10

28

hrs.

min.

9. Birthplace Wirtz, Franklin Co., Va.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Irvin Lee Divers

13. Birthplace

Wirtz, Va.

MOTHER

14. Maiden name

Geneva Powell

15. Birthplace

Wirtz, Va.

16. Informant

Irvin Lee Divers

Address

Salem, Va.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

3/31/45

(month) (day) (year)

Cemetery or crematory

Oak Hill

Location

Near Salem, Va.

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 March 1945Elizabeth E. Heck

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH March 18 19 45 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 18 19 45 at 3 P M

Immediate cause of death

Compound fracture of skull

Due to

Shock, hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

15 min

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3. 18. 45Where did injury occur? Mt. Pleasant Frederick Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Route 26Means of injury automobile Injured at work? no

23. SIGNATURE

Dr. R. W. ... M. D. or other 3. 19. 45

RECEIVED

MAR 20 1945

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02889 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick City
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Frederick City HospitalHow long in hospital or institution? 1 day

3. (a) FULL NAME

Eyer, Mr. William - Edward

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Viola Stetzel Eyer6. (c) If alive, give age 40 years7. Birth date of deceased (mo., day, yr.) August 30, 1904

8. AGE:

Years 40 Months 6 Days 11 If less than one day _____ hrs. _____ min.9. Birthplace Emmitsburg, Fred's Co. Md.
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business Md. State Sanatorium12. Name Joseph Eyer13. Birthplace Emmitsburg, Md.14. Maiden name Nellie Hanbaugh15. Birthplace Emmitsburg, Md.16. Informant Mrs. William EyerAddress Lantz, Md.17. Burial Date thereof Mar. 14, 1945
(Burial, cremation, or removal, whichever) (month) (day) (year)Cemetery or voluntary United BrethrenLocation Thurmont, Md.18. Funeral director M. R. Creager & SonAddress Thurmont, Md.19. 12 March 1945 Elizabeth G. Hech
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Lantz
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945 at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10 1945 to March 11 1945and that I last saw him alive on March 11 1945

Immediate cause of death _____

DURATION

Acute PericarditisDue to Influenza

Due to _____

Other conditions Chronic Pericarditis

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. Austin Pearce, M.D.Address Frederick, Md. Date signed 3/11/45

CERTIFICATE OF DEATH

STATE OF NEW YORK

FILE NO.

LOCAL HEALTH DEPARTMENT

RECORDED
MAR 14 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02890

CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH:

County Frederick
 City or town New Midway
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town New Midway
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Ernest Walter Flanagan.

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Leafy Darkis
 6. (c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) September 23, 1875
 8. AGE: Years 69 Months 5 Days 20 If less than one day hrs. min.

9. Birthplace Utica Mills Frederick Co. Md.
 (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name John F. Flanagan
 13. Birthplace Utica Mills, Md.

MOTHER 14. Maiden name Minerva Snook.
 15. Birthplace Creagerstown, Md.

16. Informant Mrs. Ernest Flanagan
 Address New Midway, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 16, 1945
 (month) (day) (year)

Cemetery or crematory Mt. Hope
 Location Woodsboro, Md.

18. Funeral director M. L. Creager & Son
 Address Thurmont, Md.

19. Mar. 15 1945
 (Date rec'd by registrar)

L E Powell
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1945 at 9 P:M M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 1944 to March 11 1945
 and that I last saw him alive on March 4 1945

Immediate cause of death Pulmonary Tuberculosis DURATION 4 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Gray M.D. or other

Address Thurmont Md. Date signed 3/14/45

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

RECEIVED
APR 4 1945
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 138

CERTIFICATE OF DEATH

Reg. Dist. No. 02899

1. PLACE OF DEATH:

County Frederick
City or town State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 12/9/39
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Since 12/9/39

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

David Flynn

3. (b) Social Security Number

187-05-3832

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1902

8. AGE: Years 42 Months 3 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Meadows, Maryland
(Town, county, and state)

10. Usual occupation Steam Fitter

11. Industry or business _____

12. Name George K. Flynn

13. Birthplace Unknown

14. Maiden name Ida Pinkney

15. Birthplace Maryland

16. Informant Deceased

Address Rural

17. (Burial, cremation, or removal. Which?) buried Date thereof unknown
(month) (day) (year)

Cemetery or crematory unknown

Location W. W. Chambers

18. Funeral director W. W. Chambers

Address Washington

19. 3/20 19 45 Registrar [Signature]

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 45 at 10:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9 19 39 to March 29 19 45 and that I last saw him alive on March 29 19 45

Immediate cause of death Pulmonary Tuberculosis DURATION 7 Yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. [Signature]

Address State Sanatorium, Md. Date signed 3/20/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

DECEASED

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Jan. 26, 1943
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since Jan. 26, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 300 S. Fulton Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Harry M. Forrest

3. (b) Social Security Number

220-09-8205

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Divorced

6. (b) Name of husband or wife _____

B. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 1, 18958. AGE: Years Months Days If less than one day
49 8 11 _____ hrs. _____ min.9. Birthplace Brunswick, Md.
 (Town, county, and state)10. Usual occupation Fireman

11. Industry or business _____

12. Name Thomas Forrest13. Birthplace Maryland14. Maiden name Winnie Gaven15. Birthplace Maryland16. Informant Deceased

Address _____

17. Burial Date thereof 3/15/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery xxxxx Mt. OlivetLocation Frederick Rd., Balto., Md.18. Funeral director John Cowan & SonAddress Hollins St., Balto., Md.

19. (Date rec'd by registrar) _____ Registrar _____

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 45, at 6 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26 19 43, to Mar. 12 19 45.and that I last saw him alive on March 12 19 45.Immediate cause of death Pulmonary Tuberculosis DURATION 3 Yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. B. Lynn M. D. 3/13/45Address State Sanatorium, Md. Date signed 3/13/45

RECEIVED

APR 6 1945

BUREAU V. N.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

Reg. Dist. No. 02893 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs
 Hospital, institution, or street address where death occurred:
107 Pennsylvania Ave
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Rural Woodstock Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. —
 (If rural, give LOCATION)
 2(a) If veteran, name war —

3. (a) FULL NAME

Hegebiach Fox

3. (b) Social Security Number

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Matilda Brittle
 6. (c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) Nov 25 1851
 8. AGE: Years 93 Months 3 Days 4 If less than one day — hrs. — min.

9. Birthplace Frederick co. Md
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business —

FATHER 12. Name John Fox
 13. Birthplace Frederick co. Md
 MOTHER 14. Maiden name Mary Biggs
 15. Birthplace Frederick co Md
 16. Informant David R Fox
 Address 107 Pennsylvania Ave Fred City
 17. Burial, cremation, or removal (Which?) Burial Date thereof March 4 1945
 (month) (day) (year)
 Cemetery or crematory Int Hope
 Location Woodstock Md
 18. Funeral director L. C. Barton
 Address Walpersville Md
 19. 2 March 1945 Elizabeth G. Hecker
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 1945, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to March 1 1945
 and that I last saw him alive on March 1 1945

Immediate cause of death Hypostatic pneumonia DURATION 3 days

Due to Fracture of left thigh Feb 30

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Anatopy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE B. Thompson M. D. or other

Address Woodstock Md Date signed 3/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
MAR 6 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (743)

CERTIFICATE OF DEATH

02894

131

Reg. Dist. No.

1. PLACE OF DEATH:
County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, institution, or street address where death occurred:
123 East Patrick Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 123 East Patrick Street
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME CORA OLEVIA FRY
3. (b) Social Security Number None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S
6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) March 16, 1870
8. AGE: Years 75 Months 0 Days 4 If less than one day
.....hrs.min.

9. Birthplace Jefferson-Frederick-Maryland
(Town, county, and state)
10. Usual occupation At Home

11. Industry or business

FATHER	12. Name <u>Isaac N. Fry</u>
	13. Birthplace <u>Virginia</u>
	14. Maiden name <u>Mary E. Shaff</u>
MOTHER	15. Birthplace <u>Maryland</u>

16. Informant Miss Daisy C. Fry
Address 123 E. Patrick St., Frederick, Md.

17. Burial 3/23/45
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or St. Pauls Lutheran Cemetery
Location Jefferson, Maryland

18. Funeral director M. R. Etchison and Son
Address Frederick, Maryland

19. 22 March 1945 Elizabeth H. Hetch
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20th, 1945 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
.....18....., to.....19.....
and that I last saw him er DEAD March 20th, 1945

Immediate cause of death Coronary
ischemia

Due to arteriosclerosis
Due to

Other conditions.....
(Include pregnancy within 8 months of death)

Major findings of operations.....
.....Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P. W. Baer Physician
M. D. or other
Address Frederick, Maryland Date signed 3-21-45

RECEIVED
MAR 26 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-2

CERTIFICATE OF DEATH

02895

Reg. Dist. No. 131

1. PLACE OF DEATH:

Country Frederick
City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LifetimeHospital, institution, or street address where death occurred:
South Market StreetHow long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. South Market Street
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

OWEN FRY

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6.(a) ~~Single~~, married, widowed, ~~and divorced~~
Married6.(b) Name of husband or wife Mrs. Katie Fry6.(c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) November 2, 18868. AGE: Years 58 Months 4 Days 21 If less than one day
.....hrs.min.9. Birthplace Frederick County, Maryland
(Town, county, and state)10. Usual occupation Merchant11. Industry or business "FATHER 12. Name Richard Fry13. Birthplace Frederick County, MarylandMOTHER 14. Maiden name Helen Stine15. Birthplace Frederick County, Maryland16. Informant Mrs. Katie FryAddress Frederick, Maryland17. Burial Date thereof Mar. 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or ~~place~~ Mt. Olivet CemeteryLocation Frederick, Maryland18. Funeral director C. E. Cline & SonAddress Frederick, Maryland19. 24 March 1945 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 19 45, at 10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19
and that I last saw him 7 days live on March 23 19 45Immediate cause of death acute alcoholism DURATION 2 daysDue to chronic alcoholism 5 yearsDue to -----Other conditions --

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

RECEIVED

MAR 28 1945

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

CERTIFICATE OF DEATH

Reg. Dist. No. 02896 131

1. PLACE OF DEATH:

County FredrickCity or town Fredrick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Fredrick City HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County Phil.City or town Phil.
(If outside city or town limits, write RURAL and give nearest town)Street No. 5407 Woodlawn Ave
(If rural, give LOCATION)2.(a) If veteran, name war no ✓

3. (a) FULL NAME

Patience Gallagher

3. (b) Social Security Number

4. Sex male5. Color or race white6. (a) single, married, widowed, or divorced married6. (b) Name of husband or wife Mary Mullin6. (c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) May 17 1898? 18978. AGE: Years 47 Months 10 Days 14 If less than one day

.....hrs.min.

9. Birthplace Ireland

(Town, county, and state)

10. Usual occupation B. & O. R. R. Brakeman

11. Industry or business

12. Name John Gallagher13. Birthplace Ireland14. Maiden name unknown

15. Birthplace

16. Informant Mrs Mary Mullin GallagherAddress Phila. Penn.17. Removal Date thereof April 1 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Philadelphia Pa.18. Funeral director C. H. Fetz & BrosAddress Brunswick Maryland.19. April 1 - 1945 Elizabeth J. Heck Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

....., to

and that I last saw him alive on March 31 1945Immediate cause of death fracture of skullDURATION 1 dayDue to Fall from bridge

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3.30.45Where did injury occur? Brunswick Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) B.P. BridgeMeans of injury fall Injured at work? yes23. SIGNATURE R. W. Barr. Dept. Med. Ex.

M. D. or other

Address Fredrick Md Date signed 3.31.45

RECEIVED

RECEIVED

RECEIVED

APR 3 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

Reg. Dist. No. 131

02897

1. PLACE OF DEATH:

County... Frederick

City or town... Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:
222 West Patrick St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Frederick

City or town... Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No... 222 West Patrick Street
(If rural, give LOCATION)

2.(a) If veteran, name war... None

3. (a) FULL NAME

LEWIS BENEDICT GANNON

3. (b) Social Security Number

577-03-5709

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife... Cora Garrett Gannon

6. (c) If alive, give age... 56 years

7. Birth date of deceased (mo., day, yr.) November 8, 1936

8. AGE: Years Months Days If less than one day

58

4

14

hrs. min.

9. Birthplace... Frederick, Maryland
(Town, county, and state)

10. Usual occupation... Machinist

11. Industry or business

12. Name... William Edward Gannon

13. Birthplace... Frederick, Maryland

14. Maiden name... Alice A. Buckles

15. Birthplace... Indianapolis, Indiana

16. Informant... Mrs. Lewis Gannon

Address... Frederick, Maryland

17. Burial Date thereof... Mar. 22, 1945
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory... Mt. Olivet Cemetery

Location... Frederick, Maryland

18. Funeral director... C. E. Cline & Son

Address... Frederick, Maryland

19. 24 March 1945 - Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 22, 1945, at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 21, 1945, to Mar 22, 1945

and that I last saw him alive on Mar 21, 1945

Immediate cause of death... Cerebral Anoxia

DURATION

48 hrs

Due to...

Due to...

Other conditions... Hypertension

1 mo

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... J. H. Cline M.D.

M.D. or other

Address... Frederick, Md Date signed... Mar 24, 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MADE IN THE UNITED STATES OF AMERICA

CERTIFICATE OF DEATH

RECEIVED
MAR 28 1945
FBI

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 520

CERTIFICATE OF DEATH

0289831
Reg. Dist. No.

1. PLACE OF DEATH:

County Frederick
 City or town near Walkersville Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Rural n. Walkersville
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Reginald Eugene Ligeous

3. (b) Social Security Number

4. Sex

male 5. Color or race w 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

6.(c) It alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1942

8. AGE: Years 2 Months 11 Days 6 It less than one day
 hrs. min.

9. Birthplace nr. Creagus town, Fred. Co., Md.
(town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Ray F. Ligeous13. Birthplace Thurmont, Fred. Co.14. Maiden name Pauline E. Putman15. Birthplace Fred. Co.16. Informant Ray F. LigeousAddress Walkersville, Md.17. Burial Date thereof March 31, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium U. B. CemeteryLocation ThurmontFuneral director G. E. BartonAddress Walkersville, Md.19. 30 March 1945 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 12, 44 19..... to March 28, 45 19.....and that I last saw him alive on March 28, 45 19.....

Immediate cause of death..... DURATION

Sacrocaecal Chondroma

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel E. Costaday M. D. or otherAddress Walkersville, Md. Date signed 3/28/45

RECEIVED
APR 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02892 139

1. PLACE OF DEATH: **Frederick**
 County.....
 City or town..... **State Sanatorium, Maryland**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **Since 3/19/45**
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? **Since 3/19/45**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Maryland** County.....
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **530 W. Franklin**
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... ☒

3. (a) FULL NAME

Hom Gin (Tom Lee)

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **Yellow** 6. (a) Single, married, widowed, or divorced **Single**
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) **January 2, 1875**
 8. AGE: Years **70** Months **2** Days **18** If less than one day..... hrs. min.

9. Birthplace **California**
 (Town, county, and state)
 10. Usual occupation **Kitchen work**
 11. Industry or business.....
 12. Name..... **Hom**
 13. Birthplace **California**
 14. Maiden name..... **?**
 15. Birthplace **?**

16. Informant **Deceased**
 Address.....
 17. **Burial** Date thereof **3/23/45**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery **Rock Lorraine**
 Location **Baltimore, Md.**
 16. Funeral director **M. L. Creager & Son**
 Address **Thurmont, Md.**
 19. **3/20/45** 19.....
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **March 20** 19 **45** at **8:30 A.M.**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **March 19** 19 **45** to **March 20** 19 **45**
 and that I last saw him alive on **March 20** 19 **45**
 Immediate cause of death.....
Pulmonary Tuberculosis
 DURATION **4 Mos.**
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE..... **J.B. Lyn**
 M. D. **XXX**
 Address **State Sanatorium, Md.** Date signed **3/21/45**

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 6 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-0

CERTIFICATE OF DEATH

02900 131
Reg. Dist. No.

1. PLACE OF DEATH:

County Frederick
City or town Walkersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Frederick
City or town Walkersville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME

Ida Mae Grubill

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Frank Grubill

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 30, 1857

8. AGE: Years 87 Months 9 Days 18 If less than one day

9. Birthplace Walkersville, Fred. Co., md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Enos Barrick

13. Birthplace Frederick Co.

14. Maiden name Sophia Jones

15. Birthplace Frederick Co.

16. Informant Miss Bertha Grubill

Address Walkersville

17. Burial Date thereof Mar. 21, 1945
(Burial, cremation, or removal, when)
(month) (day) (year)

Cemetery or crematory Mt Olivet

Location Frederick md.

18. Funeral director G. C. Borton

Address Walkersville

19. 19 March 1945-
(Date rec'd by registrar)

Elizabeth G. Heck
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1945, at 7:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1937 1945 to March 18 1945

and that I last saw him alive on March 17 1945

Immediate cause of death apoplexy

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel E. Fortney
M. D. or other

Address Walkersville, Md Date signed 3/29/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
MAR 20 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 927

CERTIFICATE OF DEATH

02901
Reg. Dist. No. 144

1. PLACE OF DEATH:

County FredrickCity or town Thurmont
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FredrickCity or town Thurmont
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

Pauline M. Grable

3. (b) Social Security Number

215-20-8558

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
-------------------------	----------------------------------	---

6.(b) Name of husband or wife John H. Grable6.(c) If alive, give age 27 years7. Birth date of deceased (mo., day, yr.) December 3, 1923

8. AGE:	Years	Months	Days	If less than one day
	<u>21</u>	<u>3</u>	<u>1</u>	hrs. min.

9. Birthplace Scranton, Pa.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Joseph Smelik13. Birthplace Scranton, Pa.14. Maiden name Katie15. Birthplace Scranton, Pa.16. Informant John H. GrableAddress Thurmont, Md.17. Burial Date thereof Mar. 7, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory United BrethrenLocation Thurmont, Md.18. Funeral director M. R. Quager & SonAddress Thurmont, Md.19. March 6 19 45 Anna M. Jones
(Date rec'd by registrar) RegistrarPer Blanche S. Tyler

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 45, at 3:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 19 45 to Mar. 4 19 45and that I last saw her alive on Mar. 1 19 45Immediate cause of death Acute Endocarditis

DURATION

3 wksDue to Chronic Endocarditiscomplication ofDue to Scarlet fever

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James H. Gray M. D. or otherAddress Thurmont, Md. Date signed 3/5/45

RECEIVED
APR 4 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63a

CERTIFICATE OF DEATH

02902

Reg. Dist. No. 147

1. PLACE OF DEATH:

County Fredricks
 City or town Adgerville Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Fredricks
 City or town Adgerville Rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Alberta Green

3. (b) Social Security Number

no

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lawrence E Green

7. Birth date of deceased (mo., day, yr.)

Aug. 12 - 1875

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

6971hrsmin.

9. Birthplace

Thurmont Fred Co MD

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Registrar

20. Date of death

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 13

19

45 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 19 40 to March 13 19 45and that I last saw her alive on March 13, 19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 da

Due to

Arterio-Sclerosis? yrs

Due to

Hypertension? yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op. _____

Antopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Stanley Grubill

M. D. or other

Date signed 3/13/45

RECEIVED
APR 5 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 02903 144

1. PLACE OF DEATH:

County Frederick
 City or town Thurmont
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Thurmont
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. West Main
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____ no

3. (a) FULL NAME

Dorothy Myrtle Harbaugh.

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife William F. Harbaugh
 6. (c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) May 20, 1884
 8. AGE: Years 60 Months 9 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Lantz, Frederick Co., Md.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business Housewife.

12. Name Daniel Manahan
 13. Birthplace Lantz, Md.
 14. Maiden name Ellen Buhrman.
 15. Birthplace Lantz, Md.

16. Informant William Harbaugh
 Address Thurmont, Md.
 17. Burial Date thereof Mch. 18, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Blue Ridge
Thurmont, Md.
 Location _____

18. Funeral director M. L. Creager & Son
 Address Thurmont, Md.

19. March 17, 1945 Anna M. Jones
 (Date rec'd by registrar) Registrar
Rev. R. S. Epler

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1945 at 7 P:M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15, 1943 to March 16, 1945
 and that I last saw him/her alive on March 15, 1945

Immediate cause of death Heart disease, chronic, valvular, organic DURATION 3 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Jones M. D.

Address Thurmont Md Date signed Mar. 16, 1945

CERTIFICATE OF DEATH

RECEIVED

APR 4 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93.2

CERTIFICATE OF DEATH

02984

131

Reg. Dist. No.

1. PLACE OF DEATH:
County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks
Hospital, institution, or street address where death occurred:
100 West Fourth Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Buckeystown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war..... None

3.(a) FULL NAME ANNA REBECCA HARGETT
3.(b) Social Security Number None

4. Sex F 5. Color or race W 6.(a) ~~Single, married, widowed, or divorced~~ W
8.(b) Name of husband or wife George F. Hargett
7. Birth date of deceased (mo., day, yr.) September 24, 1868
6.(c) If alive, give age years
8. AGE: Years 76 Months 5 Days 20 If less than one day hrs. min.

9. Birthplace Loudoun County Virginia
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business
12. Name Jacob Hartman
13. Birthplace Loudoun County Virginia
14. Maiden name Alice Virts
15. Birthplace Loudoun County Virginia

16. Informant Mrs. Lester B. Bartlett
Address 100 W. 4th St., Frederick, Md.
17. Burial Date thereof 3/7/45
(Burial, cremation, or removal, which) (month) (day) (year)
Cemetery or crematory Mount Olivet Cemetery
Location Frederick, Maryland
18. Funeral director M. R. Etchison and Son
Address Frederick, Maryland

19. 5-March 1945- Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th, 1945 at 4:30P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30th 1944 to March 2d 1945
and that I last saw him/her alive on March 2d, 1945

Immediate cause of death.....
Chronic myocarditis
DURATION 2 mos.
Due to.....
Due to.....
Other conditions Bronchitis- capillary
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?
23. SIGNATURE C. H. Conley M. D.
Address Frederick, Maryland Date signed 3-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CERTIFICATE OF DEATH

RECEIVED
MAR 8 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131

02905

1. PLACE OF DEATH:

County Frederick
Frederick-Rural R. F. D. #3
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 Years
 Hospital, institution, or street address where death occurred:
Yellow Springs
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City Frederick-Rural R. F. D. #3
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Yellow Springs
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

LUCY ELLEN HARRIS

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single W widowed, or W

6. (b) Name of husband or William H. Harris

7. Birth date of deceased (mo., day, yr.) November 30, 1856
 6. (c) If alive, give age years

8. AGE: Years 88 Months 4 Days 19 If less than one day
 hrs. min.

9. Birthplace Wolfsville-Frederick-Maryland
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name John W. Lewis

13. Birthplace Frederick County Maryland

14. Maiden name Maria Meisinger

15. Birthplace Frederick County Maryland

18. Informant Roy McK. Harris

Address 805 Motter Ave., Frederick, Md.

17. Burial Date thereof 3/21/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of interment Pleasant Hill Cemetery

Location Frederick, Maryland R.F.D. #3

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 20 March 1945 Elizabeth G. Heisk.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 13 - 18 to March 18 1945

and that I last saw him alive on March 18 1945

Immediate cause of death Cordis pectus

Due to Chronic Myocarditis

Other conditions Coronary atherosclerosis

Due to Chronic Myocarditis

Other conditions Coronary atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. H. Heisk. M. D.

Address Frederick, Maryland Date signed 3-20-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

RECEIVED
MAR 22 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Dist. No. 0299631

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 mo

Hospital, institution, or street address where death occurred:

South St. Frederick Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County FrederickCity or town Lewisston
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

Eugene Buchanan Holt

3. (b) Social Security Number

no

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary C. Fagle Holt

7. Birth date of deceased (mo., day, yr.)

April 19 - 1856

6. (c) If alive, give age _____ years

8. AGE:

Years 88 Months 11 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace

Lewisston Frederick Md
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Benjamin Holt

12. Name

Benjamin Holt

13. Birthplace

Lewisston Md

14. Maiden name

Marquette Hammer

15. Birthplace

Lewisston Md

16. Informant

Mrs Clarence Shambles

Address

108 E South St Frederick Md

17. (Burial, cremation, or removal. Which?)

BurialDate thereof March 14 - 45
(month) (day) (year)

Cemetery or crematorium

Lewisston Cem

Location

Lewisston Md

18. Funeral director

M. L. Greger Hager

Address

Thurmont Md19. 12 March19 45

(Date rec'd by registrar)

Elizabeth G. Hecks

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 19 45 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-3-45 19 45 to 3/11 19 45and that I last saw him alive on about 3/10/ 19 45

Immediate cause of death

Ch. Cordis - And Vascular
disease

DURATION

1 yr

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE U. S. Bessie Jr.

M. D. or other

Address Frederick Md Date signed 3-12-45

RECEIVED

MAR 14 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 25

CERTIFICATE OF DEATH

Reg. Dist. No. 144

02907

1. PLACE OF DEATH:

County Frederick
 City or town Thurmont - rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Thurmont - rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3.(a) FULL NAME

Clara B. Hoover.

3.(b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife W. Roy Hoover
 6.(c) If alive, give age 52 years
 7. Birth date of deceased (mo., day, yr.) June 10, 1894
 8. AGE: Years 50 Months 9 Days 15 11 less than one day hrs. min.
 9. Birthplace Baltimore County, Md.
 (Town, county, and state)
 10. Usual occupation Housewife.
 11. Industry or business Home.
 12. Name John W. Bowie
 13. Birthplace Baltimore County, Md.
 14. Maiden name Helen
 15. Birthplace Baltimore Co., Md.

16. Informant W. Roy Hoover.
 Address Thurmont, Md.
 17. Burial Date thereof Mar. 28, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory New Oakland
 Location Carroll County, Md.
 18. Funeral director M. L. Creager & Son
 Address Thurmont, Md.

19. Mar. 27 1945
 (Date rec'd by registrar) Anna M. Jones
Per Blanche S. Eyles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1945 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1945 to Mar 25 1945
 and that I last saw him alive on Mar 25 1945 1945

Immediate cause of death Cerebral hemorrhage

Due to Acute Hypertension

Due to Hypertension

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Morris H. Reich M. D. or other
 Address Thurmont, Md. Date signed 3/27/45

REC

APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B12)

02908

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: County <u>Frederick</u> <u>Frederick-Rural</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Emergency Hospital</u> How long in hospital or institution? <u>18½ Hours</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Frederick</u> City or town <u>Frederick</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>106 West Sixth Street</u> (If rural, give LOCATION) 2. (a) If veteran, name war <u>None</u>			
3. (a) FULL NAME <u>DAISY HURD</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>F</u>		5. Color or race <u>C</u>		6. (a) Single married, widowed, or divorced <u>M</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Oscar Hurd</u>				20. DATE OF DEATH <u>March 31st,</u> 19 <u>45</u> at <u>6:40AM</u>			
6. (c) If alive, give age <u>44</u> years				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 30</u> 19 <u>45</u> to <u>March 31</u> 19 <u>45</u> and that I last saw him or alive on <u>March 30</u> 19 <u>45</u>			
7. Birth date of deceased (mo., day, yr.) <u>January 1, 1902</u>				Immediate cause of death <u>Cardiac Decompensation</u>			
8. AGE: Years <u>43</u>		Months <u>2</u>		Days <u>30</u>		DURATION <u>2 days</u>	
8. Birthplace <u>Nr. Gaithersburg-Montgomery Md.</u> (Town, county, and state)				Due to <u>Cardio Vascular Renal</u> <u>Failure</u>			
10. Usual occupation <u>Domestic</u>				Due to			
11. Industry or business				Other conditions			
12. Name <u>William T. Scott</u>				(Include pregnancy within 3 months of death)			
13. Birthplace <u>Baltimore, Maryland</u>				Major findings of operations			
14. Maiden name <u>Louise E. Johnson</u>				Date of op.			
15. Birthplace <u>Baltimore, Maryland</u>				Autopsy results			
16. Informant <u>Oscar Hurd</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
Address <u>106 W. 6th St., Frederick, Md.</u>				22. VIOLENCE: If death was due to external causes, fill in the following:			
17. Burial <u>4/2/45</u>				Accident, suicide, or homicide. Date of			
(Burial, cremation, or removal, when) (month) (day) (year)				Where did injury occur? (City or town) (County) (State)			
Cemetery or crematory <u>Fairview Cemetery</u>				Injured at home, farm, industry, public place (where?)			
Location <u>Frederick, Maryland</u>				Means of injury Injured at work?			
18. Funeral director <u>M. R. Etchison and Son</u>				23. SIGNATURE <u>H Lawrence Tabony md</u>			
Address <u>Frederick, Maryland</u>				M. D. or other			
19. 2 April 1945				Address <u>Frederick Md</u>			
(Date read by registrar) <u>Elizabeth G. Hark</u> Registrar				Date signed <u>3-31-45</u>			

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

RECEIVED

RECEIVED
APR 3 1943
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity Doubs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity Doubs

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war. None

3. (a) FULL NAME

CHARLES ORLANDO HURLEY

3. (b) Social Security Number

None

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>S</u>
--------------------	------------------------------	--

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) February 18, 1891

6. (c) If alive, give age. years

8. AGE: Years <u>54</u>	Month <u>0</u>	Day <u>23</u>	If less than one day hrs. min.
----------------------------	-------------------	------------------	--

9. Birthplace Washington-District of Columbia
(Town, county, and state)10. Usual occupation. None

11. Industry or business

12. Name James W. Hurley13. Birthplace Virginia14. Maiden name Alice Smith15. Birthplace Kentucky16. Informant Mrs. Vernon L. FaulknerAddress Doubs, Maryland17. Burial Date thereof 3/14/45
(Burial, cremation, or removal, if cremation) (month) (day) (year)Cemetery or crematory Congressional CemeteryLocation Washington, D. C.18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 12 March 1945 Elizabeth H. Hark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11th, 1945, at 4:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....
and that I last saw him dead March 11 1945Immediate cause of death Coronary occlusion

DURATION

Due to Asthma 1 hr.Due to Pulmonary Tbc 3 yearsOther conditions healed

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury DR. Injured at work?23. SIGNATURE P. W. BauerAddress Frederick Md Date signed 3/18/45

CERTIFICATE OF DEATH

RECEIVED

MAR 14 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 115

Reg. Dist. No. 13

CERTIFICATE OF DEATH

02910

1. PLACE OF DEATH:

(a) County Frederick Co
 (b) City or town Frederick City
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution:
Frederick City Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) _____
 (e) Length of stay in this community (yrs., mos., or days) _____

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State md (b) County Montgomery
 (c) City or town Beallsville md
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. _____
 (If rural give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME

William Ira Johnson

3 (b) If veteran, name war

L

3 (c) Social Security

No. L

4. Sex

Male

5. Color or race

Negro

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

L

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

3/28/1931

8. AGE: Years

13

Months

11

Days

25

If less than one day

____ hr. ____ min.

9. Birthplace

Beallsville md
 (Town, county, and state)

10. Usual occupation

None

11. Industry or business

none

MOTHER FATHER

12. Name

Ira J. Jurnerstine Johnson

13. Birthplace

Buck Lodge md

14. Maiden Name

Ethel May Hood

15. Birthplace

Beallsville md

16 (a) Informant

Ethel Moore

(b) Address

Beallsville md

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

3/25/1945
 (month) (day) (year)

(c) Cemetery or crematory

Poplesville

Location

Poplesville md

18 (a) Funeral director

Lourence H. Davis

(b) Address

Poplesville md

19 (a) 24 March 1945 (b)

(Date rec'd by registrar)

Elizabeth G. Heck

Registrar

MEDICAL CERTIFICATION

20. Date of death March 22 - 1945, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 - 1945, to 3/22 1945, and that I last saw him alive on 3/22 1945.

Immediate cause of death

acute nephritis

Duration

6 wks

Due to acute and chronic

6 wks

Due to Septicemia

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ---

(b) Date of occurrence _____

(c) Where did injury occur? _____
 (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
 (Specify type of place)

(e) Means of injury _____

23. Signature Byron D. White, MD
 M. D. or other

Address Poplesville, md Date signed 3/24/45

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 28 1945

BUREAU V. F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown 2411 N. Charles St., Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH

on FILM No. G 9 4 MAY 15 1945

CERTIFICATE OF DEATH

02911 38
Reg. Dist. No.

1. PLACE OF DEATH:

County Frederick
City or town New Market
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Frederick
City or town New Market Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sallie Kelly

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White widow

6. (b) Name of husband or wife William Kelly

6. (c) If alive, give age DEAD years
7. Birth date of deceased (mo., day, yr.) 1-5-1876 1878

8. AGE: Years Months Days If less than one day
67 2 10 hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name John Lewis

13. Birthplace Maryland

MOTHER 14. Maiden name Mattie Pool

15. Birthplace Maryland

16. Informant Mrs. John Kelly Cousin

Address New Market Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 3-18-45
(month) (day) (year)

Cemetery or crematory Pleasant Hill

Location Near Monrovia Md.

18. Funeral director W. E. Falconer

Address New Market Md.

19. Mar 16 19 45 Lucian K. Falconer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 45 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 19 45 to Mar 15 19 45 and that I last saw her alive on March 13 19 45

Immediate cause of death Carcinoma of breast DURATION 2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest P. Roop, M.D. M. D. or other

Address New Market Md. Date signed Mar 16 1945

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF CLERK

11. SIGNATURE OF JUDGE

12. SIGNATURE OF SHERIFF

13. SIGNATURE OF CORONER

14. SIGNATURE OF DISTRICT ATTORNEY

15. SIGNATURE OF COUNTY CLERK

16. SIGNATURE OF TOWNSHIP CLERK

17. SIGNATURE OF VILLAGE CLERK

18. SIGNATURE OF CITY CLERK

19. SIGNATURE OF STATE CLERK

20. SIGNATURE OF NATIONAL CLERK

RECEIVED
APR 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 02912 / 81

1. PLACE OF DEATH:

County..... Frederick
 City or town..... Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 10 yrs.
 Hospital, institution, or street address where death occurred:
 Frederick City Hospital
 How long in hospital or institution?..... 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Frederick
 City or town..... Rural - near Frederick Junction
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... Spanish American War

3. (a) FULL NAME

JACOB ALEXANDER KIDWILER

3. (b) Social Security Number

None

4. Sex..... Male
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Fannie E. Kidwiler

6. (c) If alive, give age..... 53..... years

7. Birth date of deceased (mo., day, yr.)..... December 27-1874

8. AGE: Years..... 70 Months..... 2 Days..... 4 If less than one day..... hrs. min.

9. Birthplace..... Bakerton, West Virginia
(Town, county, and state)

10. Usual occupation..... Retired Merchant

11. Industry or business

FATHER 12. Name..... James Emanuel Kidwiler
 13. Birthplace..... Jefferson Co. West Virginia

MOTHER 14. Maiden name..... Barbara Ann Hauser
 15. Birthplace..... Washington Co. Maryland

16. Informant..... Mrs. J.A. Kidwiler
 Address..... nr. Frederick, Junction, Md.

17. Burial (Burial, cremation, or removal. Which?)..... Date thereof..... March 6-1945
 (month) (day) (year)
 Cemetery or crematory..... Mount Olivet Cemetery
 Location..... Frederick, Md.

18. Funeral director..... C.E. Cline and Son
 Address..... Frederick, Md.

19. 5th March 1945..... Elizabeth G. Hetch..... Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 3rd..... 1945..... at 6:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12th 1944 to March 3d 1945 and that I last saw him alive on March 2d 1945.

Immediate cause of death..... Metastatic Adenocarcinoma
 DURATION..... Unknown

Due to..... Primary site not determined

Probably primary in prostate gland
 Due to..... Cancer

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Peri-Aortic Tissue - - Date of op. - - -

Autopsy results..... Metastatic Adenocarcinoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... C. H. Conley..... M. D. 1881K

Frederick, Maryland
 Address..... Date signed..... 3/12/45

RECEIVED
MAR 14 1945
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

CERTIFICATE OF DEATH

02913/44
Reg. Dist. No.

1. PLACE OF DEATH;

County Frederick
 City or town Graceland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Thirty-five years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Graceland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Josephine Evelyn Layman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Charles Edward Layman
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept 25 1863
 8. AGE: Years 81 Months 5 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

FATHER 12. Name Egna Evelyn13. Birthplace MDMOTHER 14. Maiden name Elizabeth Moser15. Birthplace MD16. Informant Annabel KuppertAddress Graceland Md.17. Burial Date thereof March 12 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory United BrethrenLocation Thurmont18. Funeral director Willhild & GregerAddress Thurmont, Md.19. Mar 9 45 Anna M. Jones
 (Date rec'd by registrar) Registrar Rev. Blanchard E. Tyler

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1944, to Mar 8 1945, and that I last saw him alive on March 7 1945.

Immediate cause of death Cerebral HemorrhageDURATION 3 mos.Due to Chronic Intermit. Solitons10 yrs

Due to _____

Other conditions Hemiplegia - Gangrene
of left foot
 (Include pregnancy within 3 months of death)

2 wks

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Morris A. Bieby MD M. D. or other _____Address Thurmont Md. Date signed 3/8/45

RECEIVED

APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02914

Reg. Dist. No. 139

1. PLACE OF DEATH:

County FrederickCity or town Garfield
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty FrederickCity or town Garfield
(If outside city or town limits, write RURAL and give nearest town)Street No. no
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ann Moriah Lewis

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Daniel Lewis

7. Birth date of

deceased (mo., day, yr.)

July 18, 1846

8. AGE:

Years

Months

Days

If less than one day

988hrs.min.

9. Birthplace

Smithsburg

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

John Baker.

13. Birthplace

Smithsburg, Md.

14. Maiden name

Catherine Eckard

15. Birthplace

Smithsburg Md

16. Informant

Mr. Benjamin Lewis

Address

Garfield, Md.

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St Bethel Cem.

Location

Garfield, Md.

18. Funeral director

M. L. Creager & Son

Address

Thurmont, Md.

19.

(Date rec'd by registrar)

Feb. 20 19452 H A York

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 18 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1 1945 to Mar 18 1945and that I last saw him alive on Mar 18 1945

Immediate cause of death

Coronary Hemorrhage 4 days

Due to

Arterio Sclerosis 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H C H of L
M. D. or other

Address

Smithsburg

Date signed

3/19/45

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02915

Reg. Dist. No. 141

1. PLACE OF DEATH:

County FrederickCity or town Brunswick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

Schuman's HospitalHow long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County LondonCity or town Burial Grounds with VA
(If outside city or town limits, write RURAL and give nearest town)Street No. near the mountain
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Esther V. Lewis

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

June 12 1858

8. AGE:

Years

Months

Days

If less than one day

86828

.....hrs.min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Robert S. Lewis

13. Birthplace

va

14. Maiden name

Loretta Lynn

15. Birthplace

Virginia

16. Informant

R. S. Lewis

Address

Lorettsville Va

17.

(Burial, cremation, or removal. Which?)

Date thereof

Mar 14 1945

Cemetery or crematory

Burial Union

Location

Lorettsville Virginia

19. Funeral director

B. A. Tate & Bro

Address

Brunswick Md.

19.

(Date rec'd by registrar)

19 45Emma Martin

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March, 11 19 45, at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March, 4 19 45 to March, 11 19 45and that I last saw him/her alive on March, 11 19 45

Immediate cause of death

Fracture of (Right) neck of Femur

DURATION

1 wk.

Due to

Fall

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3/4/45Where did injury occur? Lorettsville, Va
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of Injury Fell in Room Injured at work? no

23. SIGNATURE

W B Caspuler

M. D. or other

Address Lorettsville, Va Date signed 4/11/45

RECEIVED

APR 3 1945

BUREAU T.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02916

1. PLACE OF DEATH

County Frederick Registration Dist. No. 136
 Village or City Dr. Hyattstown ND. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Edmund Wagner McE. Fresh
 (a) Residence: No. _____ St. _____ Ward _____
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Jane E. McE. Fresh</u>		
6. DATE OF BIRTH (month, day, and year) <u>May 20-1864</u>		
7. AGE Years <u>80</u>	Months <u>10</u>	Days <u>10</u> If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.	
	10. Data deceased last worked at this occupation (month and year) <u>9-44</u>	
	11. Total time (years) spent in this occupation <u>Life</u>	

MOTHER FATHER	12. BIRTHPLACE (city or town) (State or country) <u>Dr. Hyattstown Frederick Co. Ind.</u>
	13. NAME <u>Edmund W. McE. Fresh</u>
	14. BIRTHPLACE (city or town) (State or country) <u>Maryland</u>
	15. MAIDEN NAME <u>Mary A. McE. Fresh</u>
	16. BIRTHPLACE (city or town) (State or country) <u>Maryland</u>
	17. INFORMANT (Address) <u>Bessie H. H. H. Hyattstown Ind.</u>
18. BURIAL, CREMATION, OR REMOVAL Place <u>Hyattstown</u> Date <u>4-2</u> , 19 <u>45</u>	
19. UNDERTAKER (Address) <u>W. L. Burdette Hyattstown Ind.</u>	
20. FILED <u>4/2</u> , 19 <u>45</u> <u>G. O. Hendrickson</u> Registrar.	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March 30, 1945
 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Feb 20, 1945, to March 30, 1945
 I last saw him alive on March 29, 1945; death is said to have occurred on the data stated above, at 3 P. m.
 The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Myocardosis
Arterio sclerosis

Date of onset
1943
1935

Other Contributory Causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIDEL ENCE) fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____
 (Specify city or town, county and State)
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify Ernest P. Roof M. D.
 (Signed) New Market, Md.
 (Address)

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

02917

Reg. Dist. No. 145

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Vallie Lucinda Michael

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Harry Michael

7. Birth date of deceased (mo., day, yr.)

Sept. 19, 1871

8. (c) If alive, give age..... years

66

8. AGE:

Years	Months	Days	If less than one day
73	6	11	hrs. min.

9. Birthplace

Myersville, Frederick County, Md.

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Michael

13. Birthplace

Myersville, Md.

14. Maiden name

Lucinda Beardsley

15. Birthplace

Myersville, Md.

16. Informant

Harry Michael

Address

Myersville

17. (Burial, cremation, or removal, which)

Burial

Date thereof

Apr. 2, 1945

(month) (day) (year)

Cemetery or crematory

United Brethren

Location

Myersville, Md.

18. Funeral director

Fidelity Company

Address

Myersville, Md.

19. (Date rec'd by registrar)

April 2, 1945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 30, 1945 at 3 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1945, to March 30, 1945.

and that I last saw him alive on March 30, 1945.

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

G. W. Lillan M.D.

Address..... Boonsboro, Md. Date signed 3/31/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

1000

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

APR 30 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

02918

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick-Rural R. F. D. #3
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
Wilson Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick-Rural R. F. D. #3
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Wilson Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

AMANDA ALICE MILLER

3. (b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>W</u>
6. (b) Name of husband or wife <u>John W. Miller</u>		
7. Birth date of deceased (mo., day, yr.) <u>August 6, 1865</u>		
8. AGE:	Years <u>79</u>	Months <u>6</u>
	Days <u>25</u>	If less than one dayhrs.min.

9. Birthplace New Midway-Frederick-Maryland
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Andrew J. Eyler

13. Birthplace Frederick County Maryland

MOTHER 14. Maiden name Sarah Albaugh

15. Birthplace Frederick County Maryland

16. Informant Roy E. Miller

Address Frederick, Maryland R. F. D. #3

17. Burial Date thereof 3/4/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Olivet Cemetery

Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son

Address Frederick, Maryland

19. 2 March 19 45 Elizabeth G. Heck

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st, 19 45 at 3:15A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 25 to Feb 28 and that I last saw him alive on Feb 28 at 8:15 PM

Immediate cause of death Cerebral Hemorrhage
 Due to Sterile Sternum
 Due to Cerebral Hemorrhage

DURATION

4 days
107 days
192 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. H. Hedg M. D.

Address Frederick, Maryland Date signed 3-1-45

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

 2411 N. Charles St., Baltimore *Bt*

CERTIFICATE OF DEATH

02919

Reg. Dist. No. 139

1. PLACE OF DEATH: Frederick
 County.....
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since March 20, 1945
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since March 20, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
Maryland
 State..... County.....
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 616 N. Augusta Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME
William D. Mollman
 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 8. AGE: Years 55 Months 1 Days 25 It less than one day
 7. Birth date of deceased (mo., day, yr.) January 23, 1890
 B. (c) If alive, give age..... years

9. Birthplace Maryland
 (Town, county, and estate)
 10. Usual occupation Lithographer
 11. Industry or business
 12. Name Unknown
 13. Birthplace "
 14. Maiden name Unknown
 15. Birthplace "

16. Informant Information taken from application blank for admission.
 Address

17. Burial Date thereof 3/22/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery Loudon Park
 Location Baltimore, Maryland
 18. Funeral director M. L. Creager & Son
 Address Thurmont, Maryland
 19. 3/10/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 45 at 9:55 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 19 45 to Mar. 20 19 45
 and that I last saw him alive on March 20 19 45

Immediate cause of death Pulmonary Tuberculosis DURATION 1 Mo.
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE J. B. Lynn M. D. XXXX
 Address State Sanatorium, Md. Date signed 3/22/45

CERTIFICATE OF DEATH

RECEIVED
MAR 31 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

CERTIFICATE OF DEATH

02920

Reg. Dist. No. 131

1. PLACE OF DEATH

County FrederickCity or town Frederick City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Frederick P.O.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Elsie Mullins

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

William J. S. Mullins8. (c) If alive, give age 77 years

7. Birth date of

deceased (mo., day, yr.)

May 1, 1886

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

58 10 24

9. Birthplace

Montgomery Co Md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

12. Name

Richard Burditt

13. Birthplace

Montgomery Co Md

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mr. William J. S. Mullins

Address

Morrisville Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 22, 1945
(month) (day) (year)

Cemetery or crematory

Bethesda Md

Location

Montgomery Co Md

18. Funeral director

Rev. W. Barber

Address

Logansville Md19. 24 March 1945 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ to _____

and that I last saw him on March 24 1945Immediate cause of death Infection

DURATION

10 weeksDue to Burns of thighsabdomen & left handDue to 2nd & 3rd degree

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Jan 13, 45Where did injury occur? Morrisville Frederick Co Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Neighbors HomeMeans of injury Poured coal oil in Injured at work? no
stone which exploded.23. SIGNATURE P. W. Ban M. D. or otherAddress Frederick, Md Date signed 3.24.45

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

RECEIVED

MAR 28 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

02921

Reg. Dist. No. 139

1. PLACE OF DEATH: County <u>Frederick</u> City or town <u>State Sanatorium, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Since June 26, 1944</u> Hospital, institution, or street address where death occurred: <u>Maryland Tuberculosis Sanatorium</u> How long in hospital or institution? <u>Since June 26, 1944</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County _____ City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>737 W. Fayette</u> (If rural, give LOCATION) 2.(a) If veteran, name war _____			
3. (a) FULL NAME <u>Clinton Oliver</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>Male</u>				5. Color or race <u>White</u>			
6. (a) Single, married, widowed, or divorced <u>Single</u>				MEDICAL CERTIFICATION			
8. (b) Name of husband or wife _____				20. DATE OF DEATH <u>March 1</u> 19 <u>45</u> at <u>7:45 P.</u> M.			
7. Birth date of deceased (mo., day, yr.) <u>Sept. 18, 1902</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>June 26</u> 19 <u>44</u> to <u>March 1</u> 19 <u>45</u> and that I last saw him alive on <u>March 1</u> 19 <u>45</u>			
8. AGE: Years <u>42</u> Months <u>5</u> Days <u>11</u> If less than one day _____ hrs. _____ min.				Immediate cause of death <u>Pulmonary Tuberculosis</u>			
9. Birthplace <u>Baltimore, Md.</u> (Town, county, and state)				DURATION <u>14 Mos.</u>			
10. Usual occupation _____				Due to _____			
11. Industry or business <u>Produce</u>				Due to _____			
12. Name <u>? Oliver</u>				Other conditions _____			
13. Birthplace <u>Baltimore, Md.</u>				(Include pregnancy within 3 months of death)			
14. Maiden name <u>Annie ?</u>				Major findings of operations _____			
15. Birthplace <u>Baltimore, Md.</u>				_____ Date of op. _____			
16. Informant <u>Deceased</u>				Autopsy results _____			
Address _____				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>3/5/45</u> (month) (day) (year)				22. VIOLENCE: If death was due to external causes, fill in the following:			
Cemetery or crematorium <u>XXXXX New Cathedral</u>				Accident, suicide, or homicide _____ Date of _____			
Location <u>Baltimore, Md.</u>				Where did injury occur? _____ (City or town) _____ (County) _____ (State)			
16. Funeral director <u>M. L. Creager & Son</u>				Injured at home, farm, industry, public place (where?) _____			
Address <u>Thurmont, Maryland</u>				Means of injury _____ Injured at work? _____			
19. (Date rec'd by registrar) <u>3/1/45</u> 19 _____				23. SIGNATURE <u>J. B. Lynn</u>			
Registrar _____				M. D. PHYSICIAN _____			
Address <u>State Sanatorium, Md.</u>				Date signed <u>3/2/45</u>			

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-8

CERTIFICATE OF DEATH

02922

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since June 16, 1937
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since June 16, 1937

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2014 N. Monroe St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Margaret C. O'Neill

3.(b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>	
6.(b) Name of husband or wife _____			
8.(c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>July 12, 1900</u>			
8. AGE: Years <u>44</u>	Months <u>8</u>	Days <u>8</u>	If less than one day _____.hrs. _____.min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Wrapper

11. Industry or business _____

12. Name Patrick O'Neill

13. Birthplace Ireland

14. Maiden name Anna Bray

15. Birthplace Maryland

16. Informant Deceased

Address _____

17. Burial Date thereof 3/22/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery New Cathedral

Location Baltimore, Maryland

18. Funeral director William Cook

Address St. Paul St., Balto., Md.

19. 3/20/45 19_____
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 16 1937 to March 20 1945
 and that I last saw her alive on March 20 1945

Immediate cause of death Pulmonary Tuberculosis DURATION 32 Yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____ M. D. XXXXX

Address State Sanatorium, Md. Date signed 3/20/45

BUREAU V.S.

MAR 26 1945

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 88a

CERTIFICATE OF DEATH

02923

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
38 E. 2nd. St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 38 E. 2nd. St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

CHARLOTTE ELIZABETH PYLES

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Dr. Joseph T. Pyles

7. Birth date of deceased (mo., day, yr.) June 10-1883 8. (c) If alive, give age 61 years

8. AGE: Years 61 Months 9 Days 9 If less than one day hrs. min.

9. Birthplace Frederick County Maryland
 (Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

12. Name Joseph E. Bowers13. Birthplace Frederick, Md.14. Maiden name Emma Kate Lorentz15. Birthplace Frederick, Md.16. Informant Mrs. Foster K. BurketAddress Altoona, Penna.

17. Burial (Burial, cremation, or other method) 3/22/45
 Date thereof (month) (day) (year)

Cemetery or Mount Olivet CemeteryLocation Frederick, Md.18. Funeral director C.E. Cline and SonAddress Frederick, Md.

19. 90 March 1945 Elizabeth G. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1945 at 11 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from now 1944 to March 19 1945and that I last saw him alive on March 12 1945Immediate cause of death Cerebral hemorrhage

DURATION

3 hrs.

Due to Myocardial infarction & arteriosclerosis 5 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Bau M. D. or otherAddress Frederick Md Date signed 3. 20. 45

UNITED STATES DEPARTMENT OF HEALTH

CENTRIC / DEATH

RECEIVED
MAR 22 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 970

CERTIFICATE OF DEATH

02924

Reg. Dist. No. 141

1. PLACE OF DEATH:

County FredrickCity or town Brunswick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Schnaufer HospitalHow long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County LondonCity or town Leedsville
(if outside city or town limits, write RURAL and give nearest town)Street No. -
(If rural, give LOCATION)2.(a) If veteran, name war 210 ✓

3. (a) FULL NAME

James Harvey Reed

3. (b) Social Security Number

226-26-36274. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Bessie Frye7. Birth date of deceased (mo., day, yr.) Oct. 6 1884 6.(c) If alive, give age - years8. AGE: Years 60 Months 5 Days 2 If less than one day - hrs. - min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Painter11. Industry or business Painting12. Name James R. Reed13. Birthplace Virginia14. Maiden name Mary Smith15. Birthplace Virginia16. Informant Evelyn M. BrownAddress Leedsville17. Burial Date thereof Mar 10 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Lutheran UnionLocation Leedsville Va16. Funeral director C. H. Zieker BrosAddress Brunswick Md.19. March 5 1945 E. H. Zieker Bros

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945 at 11:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1945 to March 8 1945and that I last saw him alive on March 8 1945

Immediate cause of death

DURATION

Coronary Thrombosis 3 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Brunswick, Md. Date signed March 8 45

18020

STANDARD FORM NO. 64

RECEIVED
APR 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 177

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Frederick City Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Thurmont - rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2. (a) If veteran, name war no

3. (a) FULL NAME

Robert Franklin Reed.

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 21, 1915 8. (c) If alive, give age 29 years

8. AGE: Years 29 Months 7 Days 13 If less than one day hrs. min.

9. Birthplace Thurmont, Frederick Co., Md.
(Town, county, and state)

10. Usual occupation At home

11. Industry or business Laborer

12. Name Charles Richard Reed

13. Birthplace Thurmont, Md.

14. Maiden name Rose L. Freshman

15. Birthplace Thurmont, Md.

16. Informant Charles Richard Reed

Address Thurmont, Md.

17. Burial March 7, 1945
(Burial, cremation, or removal, which) Date thereof (month) (day) (year)

Cemetery or crematory United Brethren Cem.

Location Thurmont, Md.

18. Funeral director M. L. Creager & Son

Address Thurmont, Md.

19. 7 March 19 45 Elizabeth G. Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 45 at 10:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27 19 45 to Mar 4 19 45

and that I last saw him alive on Mar 4 19 45

Immediate cause of death 10:35 P. M. DURATION

acute myocarditis

Due to

Due to

Other conditions Plumage Poisoning

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE EP Thomas M. D. or other

Address Frederick, Md. Date signed Mar 5

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

MAR 8 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-6) ✓

02926

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 12/18/44
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since 12/18/44

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Belair & Joppa Rds.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edward Reekers

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Separated6. (b) Name of ~~husband~~ wifeHelen Reekers6. (c) If alive, give age Unknown years

7. Birth date of

deceased (mo., day, yr.) Oct. 12, 1872

8. AGE:

Years

Months

Days

If less than one day

7258

hrs.

min.

9. Birthplace

Covington, Ky.

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

FATHER
MOTHER

12. Name

Harmon Reekers

13. Birthplace

Germany

14. Maiden name

Susie Brink

15. Birthplace

Germany

18. Informant

Deceased

Address

17.

Unknown Burial
(Burial, cremation, or removal, Which?)

Date thereof

3/24/48

(month) (day) (year)

Cemetery or crematory

Unknown 3/24/45

Location

Blue Ridge Cemetery
Thurmont, Md.

18. Funeral director

M. L. Creager & Son

Address

Thurmont, Md.

19.

3/21
(Date rec'd by registrar)

19.

40

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 45 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 18 19 44, to March 20 19 45
 and that I last saw him alive on March 20 19 45

Immediate cause of death

Carcinoma of Tongue

DURATION

6 Mos.

Due to

Due to

Other conditions

Pulmonary Tuberculosis5 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. LinM. D. of XXXX

Address

State Sanatorium, Md.

Date signed

3/20/45

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 27 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital

How long in hospital or institution?

2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 535 N. Market St
(If rural, give LOCATION)

2(a) If veteran, name war

none

3. (a) FULL NAME

Eleanor Virginia Renner

3. (b) Social Security Number

none

4. Sex

7

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Dec. 14, 1939

8. AGE:

Years

Months

Days

If less than one day

5217

hrs.

min.

9. Birthplace

Frederick, Frederick Md
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

John Renner

13. Birthplace

Thurmont, Md

MOTHER

14. Maiden name

Edna Carpenter

15. Birthplace

McKays, Md

16. Informant

John D. Renner

Address

Frederick Md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

4/3/45
(month) (day) (year)

Cemetery or crematory

Glade Cemetery

Location

Wackersville, Md

18. Funeral director

Harry E. Garty Co

Address

Frederick Md

19.

3 April
(Date rec'd by registrar)

1945-

Elizabeth G. Heck

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945 at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19 to March 31 1945

and that I last saw him alive on

Immediate cause of death Tuberculosis

DURATION

7 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3-31-45Where did injury occur? Frederick, Frederick Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury Rail road in foot Injured at work? no

23. SIGNATURE

RW. Run Deputy Med. Ex.
Address Frederick, Md Date signed 3-31-45

M. D. or other

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BHE*

CERTIFICATE OF DEATH

Reg. Dist. No. *131*

1. PLACE OF DEATH:

County *Frederick*
 City or town *Rural Frederick*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital
 How long in hospital or institution? *2 months*

3. (a) FULL NAME

Hannah Mae Remsburg

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Amos H. Remsburg

7. Birth date of deceased (mo., day, yr.)

Sept. 1 - 1876

8. (c) If alive, give age years

8. AGE:

Years *68* Months *6* Days *21* If less than one day
 hrs. min.

9. Birthplace

Middletown, Frederick County, Md.

10. Usual occupation

Housewife

11. Industry or business

Domestic

FATHER

12. Name

Lewis Smith

13. Birthplace

Burkettville, Md.

MOTHER

14. Maiden name

Jane Knight

15. Birthplace

Burkettville, Md.

16. Informant

Robert Remsburg

Address

Thurmont, Md.

17. (Burial, cremation, or removal, which?)

Burial

Cemetery or location

Southview Cemetery

Location

Middletown, Md.

18. Funeral director

Gladhill Co.

Address

*Middletown, Md.*19. *23 March* 19 *45*

(Date rec'd by registrar)

Elizabeth G. Hech

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For unborn infants give residence of mother)

State *Maryland* County *Frederick*
 City or town *Middletown*
 (If outside city or town limits, write RURAL and give nearest town)

Street No. *(If rural, give LOCATION)*

2. (a) If veteran, name war *No*

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 24* 19 *45* at *7:45 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 1* 19 *45* to *March 24* 19 *45*

and that I last saw him alive on *March 21* 19 *45*

Immediate cause of death *Uremia*

DURATION *10 days*

Due to *Chronic nephritis 2 years*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Wm. M. Smith* *25*

M. D. or other

Address *Frederick, Md.* Date signed *3-23-45*

RECEIVED
MAR 26 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02929139
Reg. Dist. No.

1. PLACE OF DEATH:

County Frederick
City or town State Sanatorium, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Oct. 14, 1943
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Since Oct. 14, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2(a) If veteran, name war _____

3. (a) FULL NAME

William A. Schmidt

3. (b) Social Security Number

218-01-3281

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

B. (b) Name of ~~husband~~ wife Alma Schmidt

B. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) August 9, 1902

8. AGE:

Years

Months

Days

If less than one day

42

6

26

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Drill Press Operator

11. Industry or business

FATHER

12. Name William H. Schmidt

13. Birthplace Pennsylvania

MOTHER

14. Maiden name Mathilda M. Kroger

15. Birthplace Washington, D. C.

18. Informant

Deceased

Address

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof 3/10/45
(month) (day) (year)

Cemetery Cedar Hill

Location Baltimore Co.

18. Funeral director

M. L. Creager & Son

Address Thurmont, Maryland

19.

(Date recd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 45 at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 14 19 43 to March 7 19 45
and that I last saw him alive on March 7 19 45

Immediate cause of death

Pulmonary Tuberculosis

DURATION

20 Mos.

Next

Tuberculous Enteritis

1 Yr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

J. B. Lynn

M. D. ~~XXXX~~

Address State Sanatorium, Md. Date signed 3/8/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 17 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (142)

CERTIFICATE OF DEATH

02930
Reg. Dist. No. 145

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

Feb 28, 1937

6. (c) If alive, give age..... years

8. AGE:

Years

8

Months

1

Days

3

If less than one day

hrs.

min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

April 2, 1945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Mar 31, 1945, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1, 1945, to Mar 31, 1945

and that I last saw him alive on

Mar 30, 1945

Immediate cause of death.....

Lymphatic Leukaemia

DURATION

3 1/2 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, to industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. S. Harp - MD

M. D. or other

Address.....

Date signed 4-1-45

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

RL
APR 30 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH
residence of deceased is shown on 2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

02931

Reg. Dist. No. 138

FILM No G 9 4 MAY 11 1945

1. PLACE OF DEATH:

County... Frederick
City or town... Bartholomew
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Frederick
City or town... Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Luther Stewart

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age... years

8. AGE Years Months Days If less than one day
about 68 hrs. min.

9. Birthplace... Frederick Co.
(Town, county, and state)

10. Usual occupation... Labor

11. Industry or business

FATHER 12. Name... West Stewart

13. Birthplace... md.

MOTHER 14. Maiden name... Mary Mullinix

15. Birthplace... md.

16. Informant... H. M. Swisher

Address... Bartholomew

17. (Burial, cremation, or removal. Which?) Date thereof March 23/1945
(month) (day) (year)

Cemetery or crematory... Howard Chapel

Location... Long Corner Howard

18. Funeral director... H. M. Swisher

Address... mt. Airy

19. Mar 19 19 45 Lucian K. Talbott
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 18 19 45, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. l. md. March 19 19 45

Immediate cause of death DURATION

Coronary occlusion 2 weeks

Due to... Chronic myocarditis 5 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Baur M. D. or other

Address... Frederick, Md Date signed 3.19.45

RECEIVED

APR 5 1945

BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

02932

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Frederick City Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Mount Airy - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near New Market
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war

3. (a) FULL NAME
ETHAN PHILIP SUMMERS, JR.

3. (b) Social Security Number
NONE

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January 28, 1945
 8. AGE: Years _____ Months 1 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick-Frederick-Maryland
 (Town, county, and state)
 10. Usual occupation Infant
 11. Industry or business
 12. Name Ethann P. Summers, Sr.
 13. Birthplace Frederick County Maryland
 14. Maiden name Marie L. Flook
 15. Birthplace Frederick County Maryland
 16. Informant Mrs. E. P. Summers, Sr.
 Address Mount Airy, Maryland - Rural

17. Burial Date thereof 3/17/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mount Olivet Cemetery
Frederick, Maryland
 Location
M. R. Etchison and Son
 18. Funeral director
 Address Frederick, Maryland

19. 17 March 1945
 (Date rec'd by registrar) Registrar Elizabeth G. Heck

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1945, at 6:15A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 26 1945, to March 16, 1945
 and that I last saw him alive on March 15, 1945
 Immediate cause of death
Collapse of lung
 DURATION
2 weeks
 Due to Following operation
(Ramstedt pyloroplasty
2 weeks
 Due to Congenital pyloric
stenosis (hypertrophic)
 Other conditions Mal-nutrition
 (Include pregnancy within 3 months of death)

Major findings of operations Congenital pyloric
stenosis Date of op. Feb. 27th
 Autopsy results No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work?

23. SIGNATURE Frank M. Overington M. D.
 M. D. or other
 Address Frederick, Maryland Date signed 3-16-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 20 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6440)

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
 County Frederick
 City or town Hansonville-rural nr. Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Hansonville - rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ✓
 (If rural, give LOCATION)
 2(a) If veteran, name war no

3. (a) FULL NAME Harold Hedges Sunday 3. (b) Social Security Number none

4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary Rebecca Stull

7. Birth date of deceased (mo., day, yr.) January 11, 1903 6. (c) If alive, give age 35 years

8. AGE: Years 42 Months 2 Days 8 If less than one day hrs. min.

9. Birthplace Hansonville, Frederick Co., Md
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Clinton R. Sunday
 13. Birthplace Hansonville, Md.

MOTHER 14. Maiden name Elsie I. Ramsburg
 15. Birthplace Charlesville, Md.

16. Informant Mrs. Harold H. Sunday.
 Address Frederick R.F.D. Md.

17. Burial (Burial, cremation, or removal-Which?) Burial Date thereof March 22, 1945
 (month) (day) (year)

Cemetery or crematory Utica Cemetery
 Location Utica, Md.

18. Funeral director M. L. Creager & Son
 Address Thurmont, Md.

19. 22 March 1945 Registrar Elizabeth G. Hech
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1945 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to 1945
 and that I last saw him ✓ on March 19, 1945

Immediate cause of death Gun shot wound of chest

Shock, hemorrhage DURATION Immediate

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Suicide Date of 3. 19. 45

Where did injury occur? near Hansonville, Frederick, Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) farm

Means of injury 12 ga. Shotgun Injured at work? no

23. SIGNATURE R. W. Baer M. D. or other

Address Frederick, Md. Date signed 3. 20. 45

RECEIVED

MAR 23 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02934

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Hour

Hospital, institution, or street address where death occurred:

185 West All Saint Street

How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 185 West All Saint Street

(If rural, give LOCATION)

None

2.(a) If veteran, name war

3. (a) FULL NAME

ALICE LUCILLE THOMPSON

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

March 10, 1945

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1

hrs.

min.

9. Birthplace Frederick-Frederick-Maryland

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER
MOTHER12. Name William A. Thompson13. Birthplace Frederick County Maryland14. Maiden name Blanche Fredericks15. Birthplace Montgomery County Maryland16. Informant Mrs. Blanche F. ThompsonAddress 185 W. All Saint St., Fred'k, Md.17. Burial

(Burial, cremation, or removal, which?)

Date thereof 3/11/45

(month) (day) (year)

Cemetery or Ebenezer CemeteryLocation Ijamsville, Maryland-Rural18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 11 March 1945

(Date rec'd by registrar)

Elizabeth G Heck

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10th, 45, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/01945

to

18and that I last saw h... alive on 3/10/4519

Immediate cause of death

Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

U. G. Bourne Jr

M. D.

M. D. or other

Address Frederick, MarylandDate signed 3-11-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 14 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 948

CERTIFICATE OF DEATH

02935

Reg. Dist. No. 141

1. PLACE OF DEATH:

County... Frederick
 City or town... Knobsville - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Frederick
 City or town... Knobsville RFD
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

E. J. Thompson
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 B. (b) Name of husband or wife Ethel Thompson

3. (b) Social Security Number

NONE

7. Birth date of deceased (mo., day, yr.) Apr. 1, 1896
 B. (c) If alive, give age 55 years

8. AGE: Years 58 Months 11 Days 23 If less than one day
 hrs. min.

9. Birthplace... Nameski Illinois
 (Town, county, and state)

10. Usual occupation... Farm Manager

11. Industry or business

12. Name... John Thompson

13. Birthplace... Indiana

14. Maiden name... Frances Cain

15. Birthplace... Illinois

16. Informant... Mrs. Ethel Thompson

Address... Knobsville Md.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Mar. 27 1945
 (month) (day) (year)

Cemetery or crematory... Reformed Cemetery

Location... Middletown, Md.

18. Funeral director... Radwell Company

Address... Middletown, Md.

19. March 23 45 E. J. Thompson Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... Mar 23 19 45 at 4:40 PM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Mar 23 19 45 to Mar 23 19 45 and that I last saw him alive on Mar 23 19 45

Immediate cause of death

Myocardial Infarction DURATION 4 hrs

Due to Coronary atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. J. Thompson M. D. or other Physician
 Address Date signed

wrong cert - not.

RECEIVED

APR 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

02936

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Rural Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 mo
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution? 8 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Frederick
 City or town Foxville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)
 2. (a) If veteran, name war WW

3. (a) FULL NAME

William Toms (of a)

3. (b) Social Security Number

h

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Clara Brown

7. Birth date of deceased (mo., day, yr.)

June 13 - 1863

8. (c) If alive, give age _____ years

8. AGE:

Years	Months	Days	It less than one day
<u>81</u>	<u>9</u>	<u>18</u>	_____ hrs. _____ min.

9. Birthplace

Foxville Fred Co MD
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

Abraham Toms

12. Name

Foxville Fred Co MD

13. Birthplace

Susan Bowman

14. Maiden name

Foxville Fred Co MD

15. Birthplace

Mrs W. A. Smith

16. Informant

Larry MD

Address

Burial

17. (Burial, cremation, or removal. Write in)

Bethel Cem

Cemetery or crematory

near Garfield Fred Co

Location

M. F. C. E. S. Corp

19. Funeral director

Thurmond MD

Address

2 April 1945Elizabeth G. HeckRegistrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 26 1944 to March 31 1945
 and that I last saw him alive on March 31 1945

Immediate cause of death

Senility

Due to

Cardiac Vascular Renal Disease

Due to

Cardiac Decomposition

Other conditions

4 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work? _____

23. SIGNATURE

H. Lawrence Falmey MDFrederick MD Date signed 3-31-45

RECEIVED BY THE DIRECTOR OF HEALTH

RECEIVED BY THE DIRECTOR OF HEALTH

RECEIVED

APR 3 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27a

CERTIFICATE OF DEATH

02937

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FredrickCity or town Fredrick - rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

Emergency HospitalHow long in hospital or institution? 9 days

3. (a) FULL NAME

Katie M. Trofoll

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 7 - 1865

8. AGE:

Years 79 Months 10 Days 15 If less than one day..... hrs. min.9. Birthplace Thurmont, Fredrick Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Alfred A. Trofoll13. Birthplace Thurmont - Maryland14. Maiden name Miranda Weller15. Birthplace Thurmont - Maryland16. Informant Mr. J. P. StyleAddress Thurmont, Md.17. Burial Date thereof Mar. 24, 1945
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory United BrethrenLocation Thurmont, Md.18. Funeral director M. R. CunninghamAddress Thurmont, Md.19. 23 March 19 45 Elizabeth G. Heide
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FredrickCity or town Thurmont
(If outside city or town limits, write RURAL and give nearest town)Street No. East Main St.
(If rural, give LOCATION)2. (a) If veteran, name war no

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1945 at 3:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 13, 1945 to Mar. 22, 1945and that I last saw him alive on March 22, 1945Immediate cause of death Paralysis

DURATION

10 daysDue to Cerebral HemorrhageDue to arterio sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. M. Smith M.D.Address Fredrick, Md. M. D. or otherDate signed 3-22-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 28 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. State every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *382*

CERTIFICATE OF DEATH

02938

Reg. Dist. No. *144*

1. PLACE OF DEATH:

County..... Frederick
 City or town..... Thurmont
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Lifetime.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Frederick
 City or town..... Thurmont
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Church Street
 (If rural, give LOCATION)
 no
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Sadie Margaret Weddle.

3.(b) Social Security Number

none

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Widow</u>
-------------------------	----------------------------------	---

6.(b) Name of husband or wife..... Charles W. Weddle
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) July 28, 1870
 8. AGE: Years 74 Months 8 Days I If less than one day
 hrs. min.

9. Birthplace..... Thurmont, Frederick Co., Md.
 (Town, county, and state)

10. Usual occupation..... Housework11. Industry or business..... Home

FATHER
 12. Name..... Elijah Willhide
 13. Birthplace..... Thurmont, Md.
MOTHER
 14. Maiden name..... Sadie Margaret Willhide
 15. Birthplace..... Thurmont - Md.

16. Informant..... Libert S. Weddle.
 Address..... Thurmont, Md.

17. Burial Date thereof..... April 1, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Blue Ridge. Cem
 Location..... Thurmont, Md.

18. Funeral director..... M. L. Creager & Son
 Address..... Thurmont, Md.

19. Mar. 31..... 1945..... Anna M. Jones Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 30, 1945 at 1:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 25..... 1945 to Mar 30..... 1945
 and that I last saw him..... alive on Mar 29..... 1945

Immediate cause of death..... Acute Myocarditis

DURATION

8 daysDue to..... Acute Rheumatism7 weeks

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Morris A. Berry MD. M. D. or otherAddress..... Thurmont - Md. Date signed 3/30/45

RECEIVED
APR 4 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

Reg. Dist. No. 141

02939

1. PLACE OF DEATH:
 County Washington Frederick
 City or town Brunswick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 days
 Hospital, institution, or street address where death occurred:
Schnauffer Hospital
 How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Lapland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Lapland Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war - none -

3. (a) FULL NAME
William Arthur Wells

3. (b) Social Security Number
219-20-3523

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February - 28 - 1886

8. AGE: Years 59 Months 0 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Birmingham Alabama
 (Town, county, and state)

10. Usual occupation Retired Mechanical Engineer

11. Industry or business

12. Name H. W. Wells

13. Birthplace Ocala Mills Penna.

14. Maiden name Ida Estep

15. Birthplace Ocala Mills Penna.

16. Informant Ralph Kaetzal

Address Lapland Md.

17. Burial Date thereof March 23 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Church of the Risen Christ

Location Brownsville Md.

18. Funeral director W. J. Best & Sons

Address Brownsville Md.

19. March 21 1945 Emma Martin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 45 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 19 45 to March 20 19 45 and that I last saw him alive on March 20 19 45

Immediate cause of death _____ DURATION _____

Cordway thromboses 3 days

Due to _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William Schnauffer M.D.

Address Brunswick Date signed March 21 45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

02940

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Fredrick
 City or town Fredrick Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Fredrick

City or town Edwardsboro
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Harry Lee Whitter

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Elizabeth Tieg7. Birth date of deceased (mo., day, yr.) February 12, 1867 6. (c) If alive, give age _____ years8. AGE: Years 78 Months 1 Days 17 If less than one day _____ hrs. _____ min.9. Birthplace Fredrick County, Maryland
(Town, county, and state)10. Usual occupation Painter

11. Industry or business _____

12. Name Gabriel Whitter13. Birthplace Fredrick County, Maryland14. Maiden name Anna Virginia Edwards15. Birthplace Fredrick County, Maryland16. Informant Virginia TiegAddress Emergency Hosp. Fredrick, Md.17. Burial Date thereof 3/30/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fatherman CemeteryLocation Church Hill Fredrick Rural18. Funeral director M. R. EtchisonAddress Fredrick, Maryland19. 29 March 19 45 Elizabeth L. Beck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 45 at 1:15 P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 3 19 45 to Mar. 29 19 45and that I last saw him alive on March 28 19 45Immediate cause of death Acute dilatation heart 2 days DURATIONDue to arterio sclerosis 10 years

Due to _____

Other conditions Senile gangrene 2 months

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm. M. Smith M.D. M. D. of other _____Address Fredrick, Md. Date signed 3-29-45

CERTIFICATE OF DEATH

RECEIVED
APR 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
711 Maxwell Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md County Hartford
 City or town Bel Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME Katherine E Wilson

3. (b) Social Security Number ✓

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband Wm D. Wilson
 7. Birth date of deceased (mo., day, yr.) January 1-1866 6. (c) If alive, give age _____ years
 8. AGE: Years 79 Months 2 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Hartford Co. Md.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business _____

12. Name John Ely
 13. Birthplace Hartford, Co., Md.
 14. Maiden name Hannah Frank Ely
 15. Birthplace Forest Hill, Md

16. Informant Mrs Frank Hamby
 Address 4202 Belmar Ave Balto Md.

17. Burial MT Zion Date thereof Mar 25/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory MT Zion
 Location near Bel Air, Md

18. Funeral director Dean & Foster
 Address Bel Air Md

19. 23 March 1945 Elizabeth G. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23, 1945, at 9:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____, and that I last saw him alive on Mar 23 1945

Immediate cause of death coronary occlusion DURATION acute

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

23. SIGNATURE R. W. Baer DR. R. W. BAER

Address Frederick Md Date signed 3-23-45

RECEIVED

MAR 28 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Frederick City Hospital
 How long in hospital or institution? 1 day

3. (a) FULL NAME

Baby Girl Yagley

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 6 - 1943 -

8. AGE:

Years

Months

Days

If less than one day

001

hrs.

min.

9. Birthplace

Frederick, Md.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or other)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Elizabeth G. Herk
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (u) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 7, 1945, at 5:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 5, 1945, to Mar 7, 1945
 and that I last saw him alive on Mar 6, 1945

Immediate cause of death

DURATION

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 3-7-45

RECEIVED STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

RECEIVED

MAR 12 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (144)

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:

County... Frederick
City or town... Thurmont.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Frederick
City or town... Thurmont
(If outside city or town limits, write RURAL and give nearest town)
Street No... Lombard Street
(If rural, give LOCATION)
no
2.(a) If veteran, name war.....

3. (a) FULL NAME

Addie Virginia Yingling

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

..... 6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) May 30, 1897

8. AGE: Years 47 Months 9 Days 16 If less than one day
..... hrs. min.

9. Birthplace Graceham, Frederick Co., Md.
(Town, county, and state)

10. Usual occupation

Retired.

11. Industry or business

12. Name Samuel Yingling
13. Birthplace Taneytown, Md.

14. Maiden name Louisa Virginia Smith
15. Birthplace Thurmont, Md.

16. Informant Mrs. Samuel Yingling
Address Thurmont, Md.

17. Burial Date thereof March 19, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory United Brethern
Location Thurmont, Md.

18. Funeral director M. L. Creager & Son
Address Thurmont, Md.

19. March 19, 1945 Anna M. Jones
(Date rec'd by registrar) (Signature) Registrar
By R. S. Eyles

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1945 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Feb 10 1945 to March 16 1945
and that I last saw her alive on March 16 1945

Immediate cause of death

Absence of lung

DURATION

5 weeks

Due to

Due to

Other conditions

Arthritic Chronic
Severe

(Include pregnancy within 3 months of death)

10 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James H. Gray M.D.
Address Thurmont, Md. Date signed 3/18/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02943

RECEIVED

APR 4 1945

BUREAU V.S.